Accountable Entity Advisory Committee

January 30, 2019

Agenda

Welcome and Introductions

Accountable Entities and Behavioral Healthcare

- Key Indicators
- Program Design Levers

Meaningfully Addressing Behavioral Health in Medicaid ACO programs

Rob Houston, Center for Healthcare Strategies

Committee Discussion

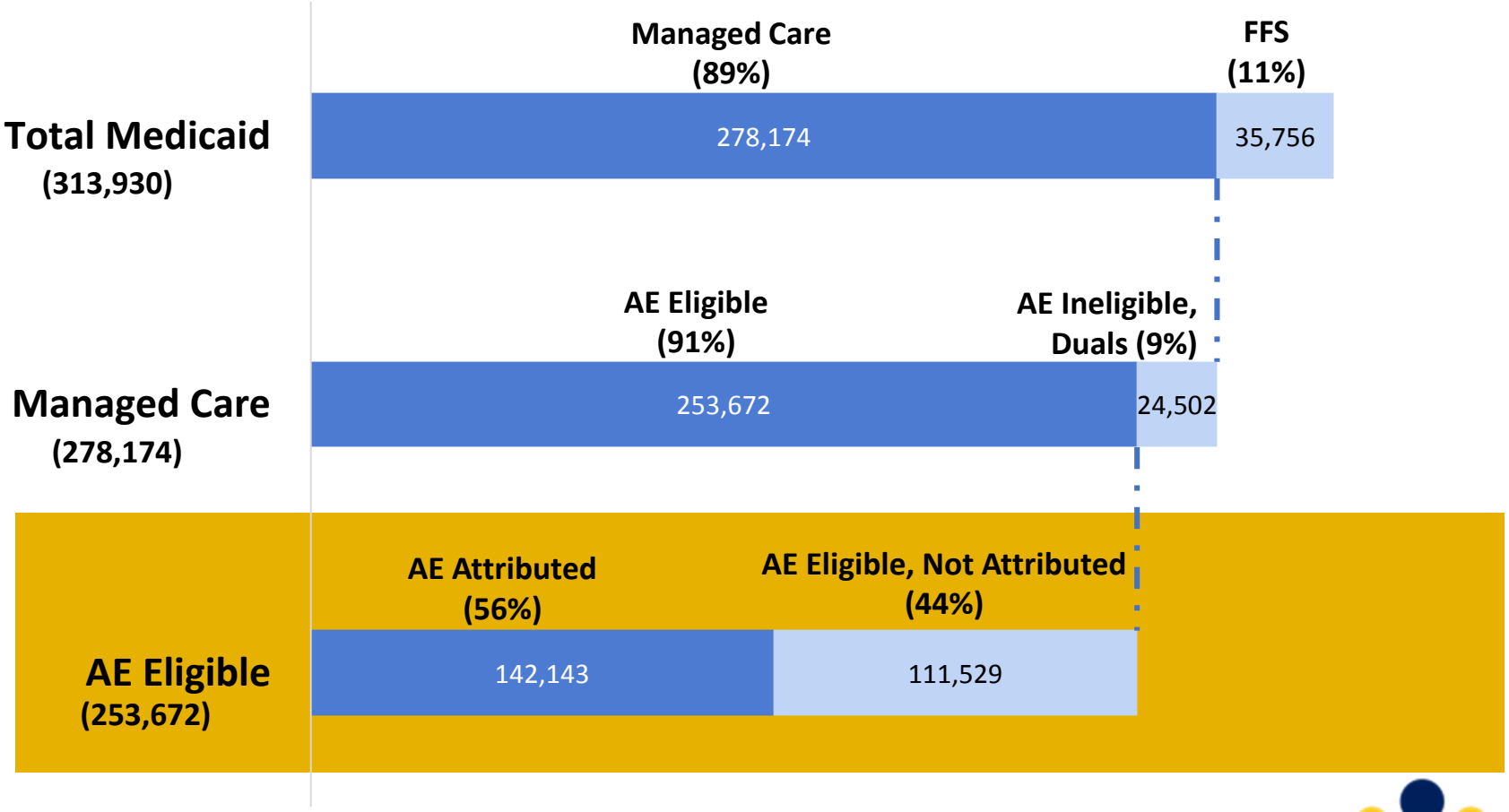
Program Updates

Public Comment

Accountable Entities and Behavioral Healthcare:

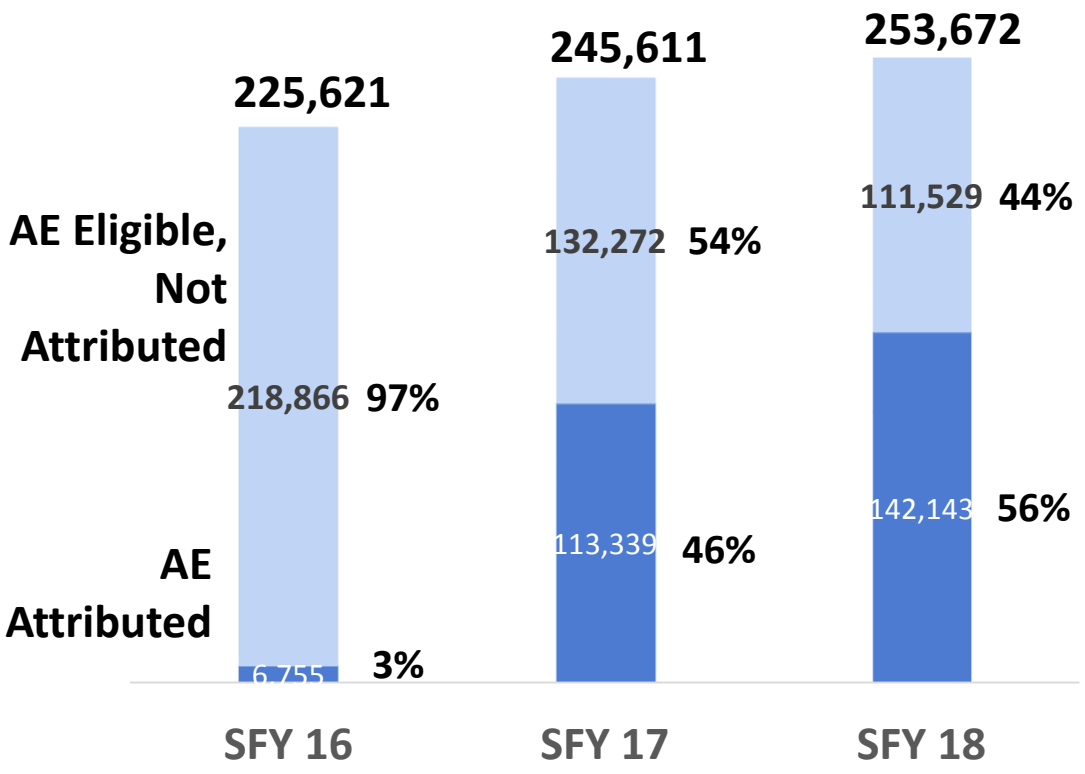
Key Indicators

AE Eligible Population = 253,672 Average Eligibles (81% Total Medicaid)



Data: Medicaid Average Eligibles, SFY 2018
Source: MMIS Claims and Eligibility Data, Package 20181213, Table IB.

The share of members attributed to an AE has increased substantially since the start of the AE program.



SFY 19
Full Program Year 1

- AE eligible members attributed to an AE has increased to approximately **68%**
- **9 MCO/AE contracts**
  5 NHP AE contracts
  4 UHC AE contracts

Data: AE Eligibles, SFY 2016 - 2018
Source: MMIS Claims and Eligibility Data, Package 20181115, Table V.

Behavioral health integration was identified as a key goal of the Reinventing Medicaid initiative, and therefore a key priority of the AE program.

February 2015 Working Group to Reinvent Medicaid

"…in order to transform Rhode Island's Medicaid program to pay for better outcomes, better coordination and higher-quality care, instead of more volume."

The initiatives focus on:

- Better coordination of mental and physical healthcare
- Better coordination of care through our managed care organizations and new provider partnerships
- A continued emphasis to shift service delivery away from institutional care and toward community-based services; and
- Better enforcement of Medicaid rules to protect against waste and fraud.

Source: http://www.eohhs.ri.gov/Initiatives/ReinventingMedicaid.aspx
AE Incentive Program Requirements

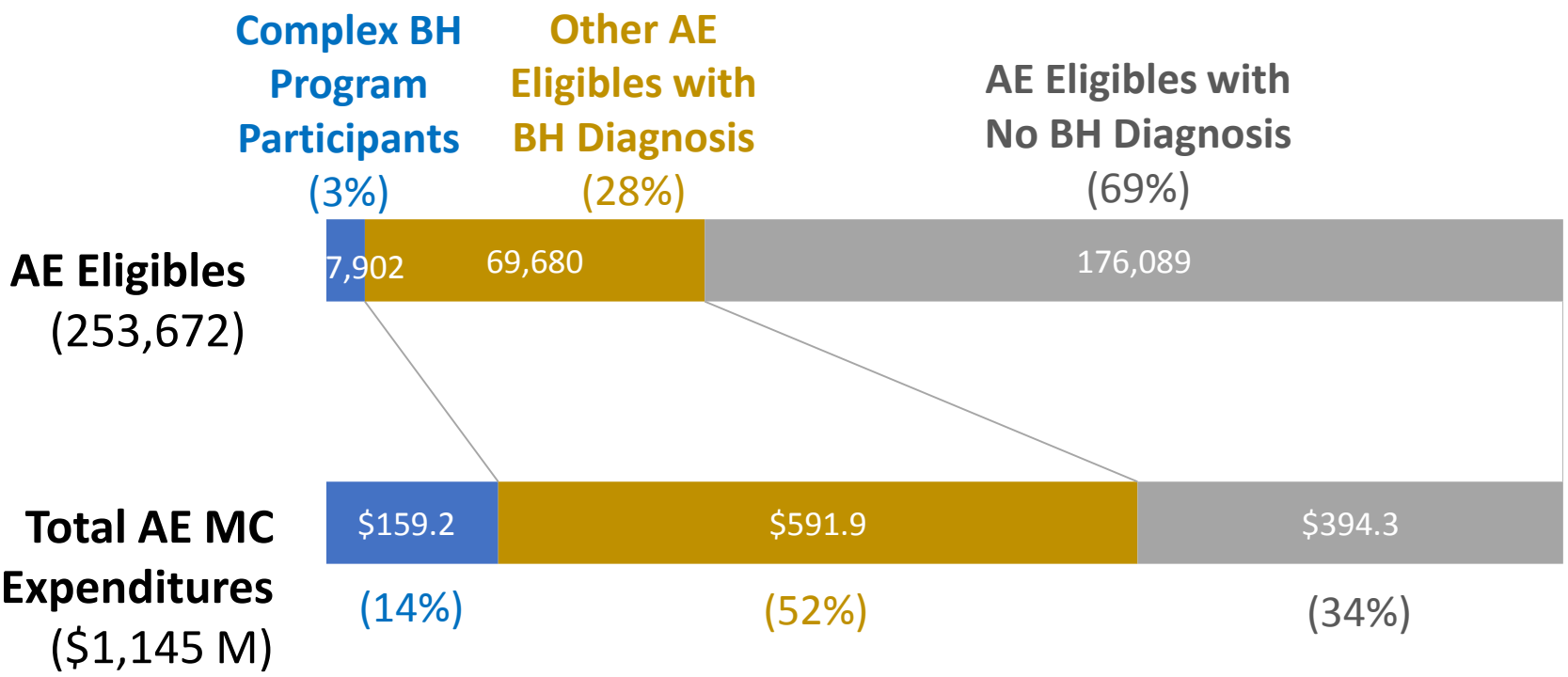
AE Eligibles with Behavioral Health Diagnoses: Definitions

- **Complex BH Program Participants**
  SPMI and/or IHH enrollees
  Includes Integrated Health Home (IHH), Assertive Community Treatment (ACT), and Opioid Health Home

- **Other AE Eligibles with a BH Diagnosis**
  Eligibles with any BH diagnosis during SFY 2018, excluding Complex BH Program Participants
  Includes ICD-10 diagnostic codes F01-F99
  Mental, Behavioral and Neurodevelopmental disorders

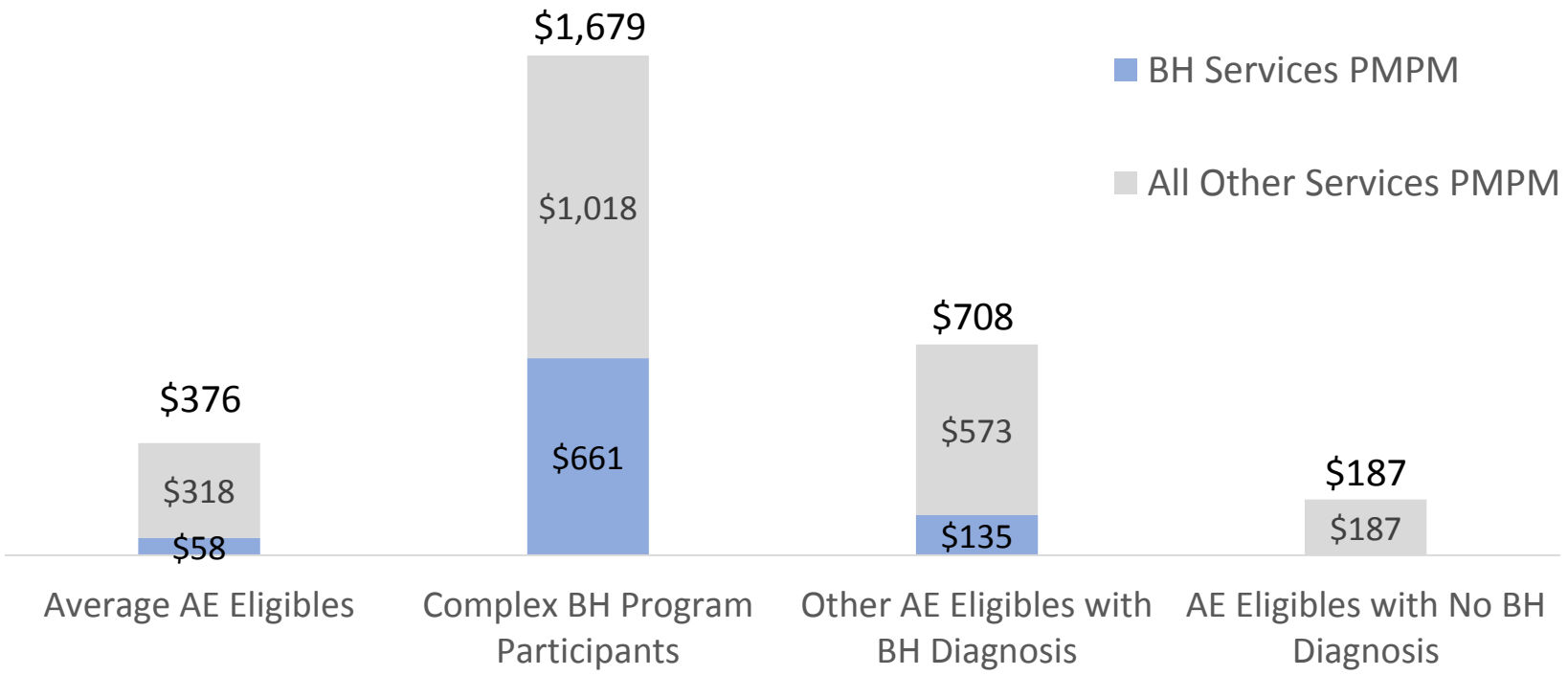
- **AE Eligibles with No BH Diagnosis**

The 31% of AE Eligibles with behavioral health diagnoses represent 66% of total AE Eligible Medicaid managed care expenditures.



Data: AE Eligible Average Eligibles by BH User Type, SFY 2018
Source: MMIS Claims and Eligibility Data, Package 20190107, Table III.

A behavioral health diagnosis is a key indicator of complexity and cost.



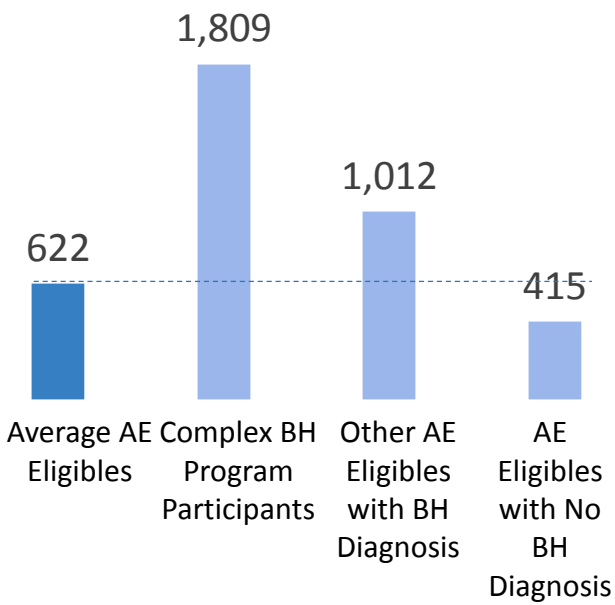
Factor Variance *vs. AE Eligibles with No BH Diagnosis PMPM*	**9.0x**	**3.8x**

Data: AE Eligible Managed Care Expenditure PMPM by BH User Type, SFY 2018
Source: MMIS Claims and Eligibility Data, Package 20190107, Table II.

AE Eligibles with behavioral health diagnoses have significantly higher Emergency Department and Inpatient utilization rates than AE Eligibles with No BH Diagnosis.

Emergency Department Utilization

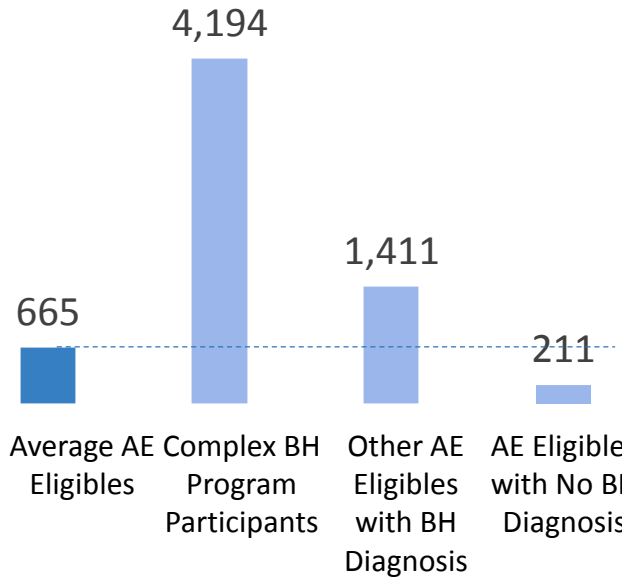
ED Visits/1,000



Factor Variance *vs. AE Eligibles with No BH Diagnosis*	4.4 x	2.4 x	

Inpatient Utilization

Inpatient Days/1,000



Factor Variance *vs. AE Eligibles with No BH Diagnosis*	19.9 x	6.7 x	

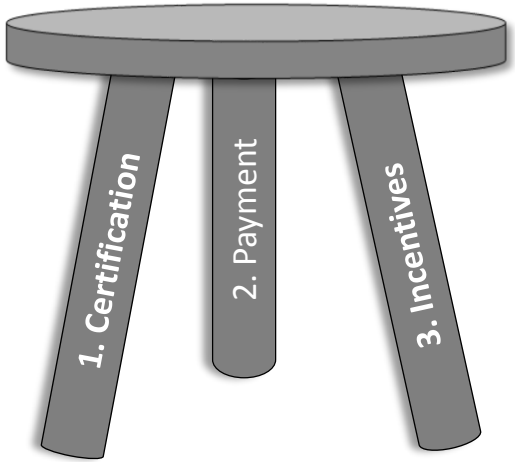
Data: AE Eligibles Utilization Rates, SFY 2018
Source: MMIS Claims and Eligibility Data, Package 20190109, Table I and II

Accountable Entities and Behavioral Healthcare:

AE Design Levers

The AE program is designed with three levers for healthcare transformation

Certification
Define expectations for network capacity, structure, processes

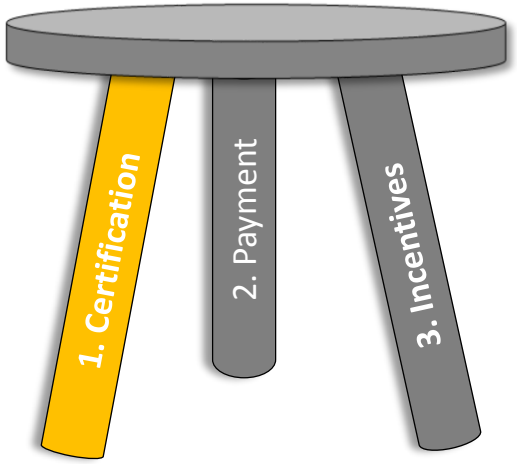


Incentives
Target financial incentives to encourage and support infrastructure development

Payment
Transition payments from a from fee-based model to a value-based payment model that considers quality

Each of these levers currently includes dimensions that seek to improve behavioral healthcare

Certification:
Define expectations for network capacity, structure, processes

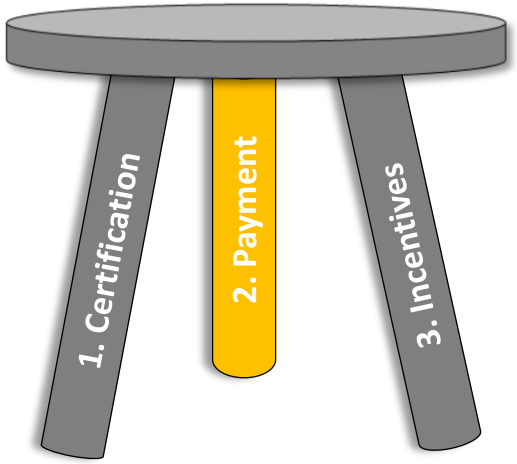


Certification requires the development of a full continuum of integrated BH services

Program Year 1 conditions of continued certification require demonstration of development of BH capacity and integration

Each of these levers currently includes dimensions that seek to improve behavioral healthcare

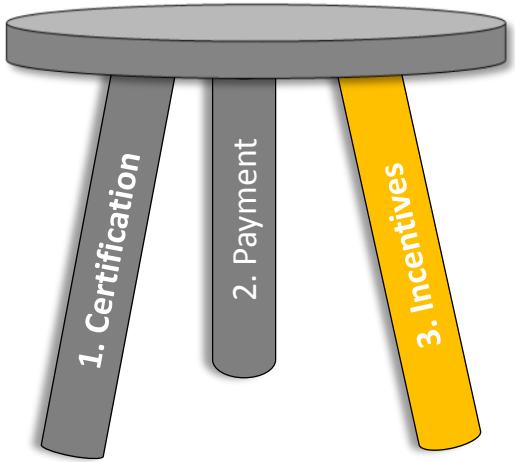
Payment:
Require transition from fee based to value based payment model that considers quality



Member attribution logic considers complex behavioral health needs first

Shared savings are adjusted in part based on behavioral health quality metrics

Each of these levers currently includes dimensions that seek to improve behavioral healthcare



Incentives:
Target financial incentives to encourage and support infrastructure development

Incentive program includes an outcome component that requires reporting on ED utilization, measuring the impact on key behavioral health populations.

AE projects approved for incentive funding must focus on core EOHHS priorities of behavioral healthcare, substance use disorder treatment, social determinants of health.

CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

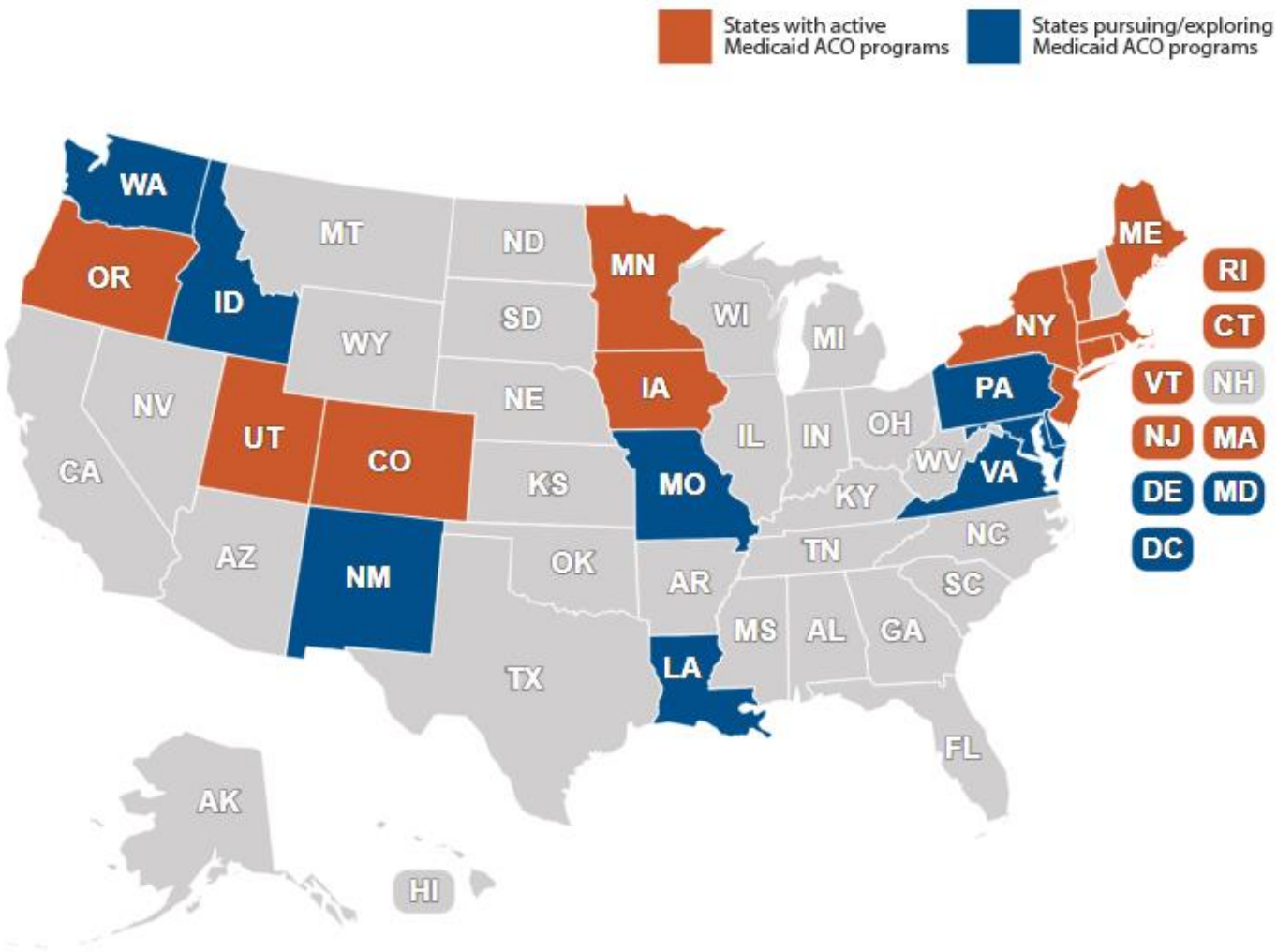
Meaningfully Addressing Behavioral Health in Medicaid ACO programs

Rob Houston

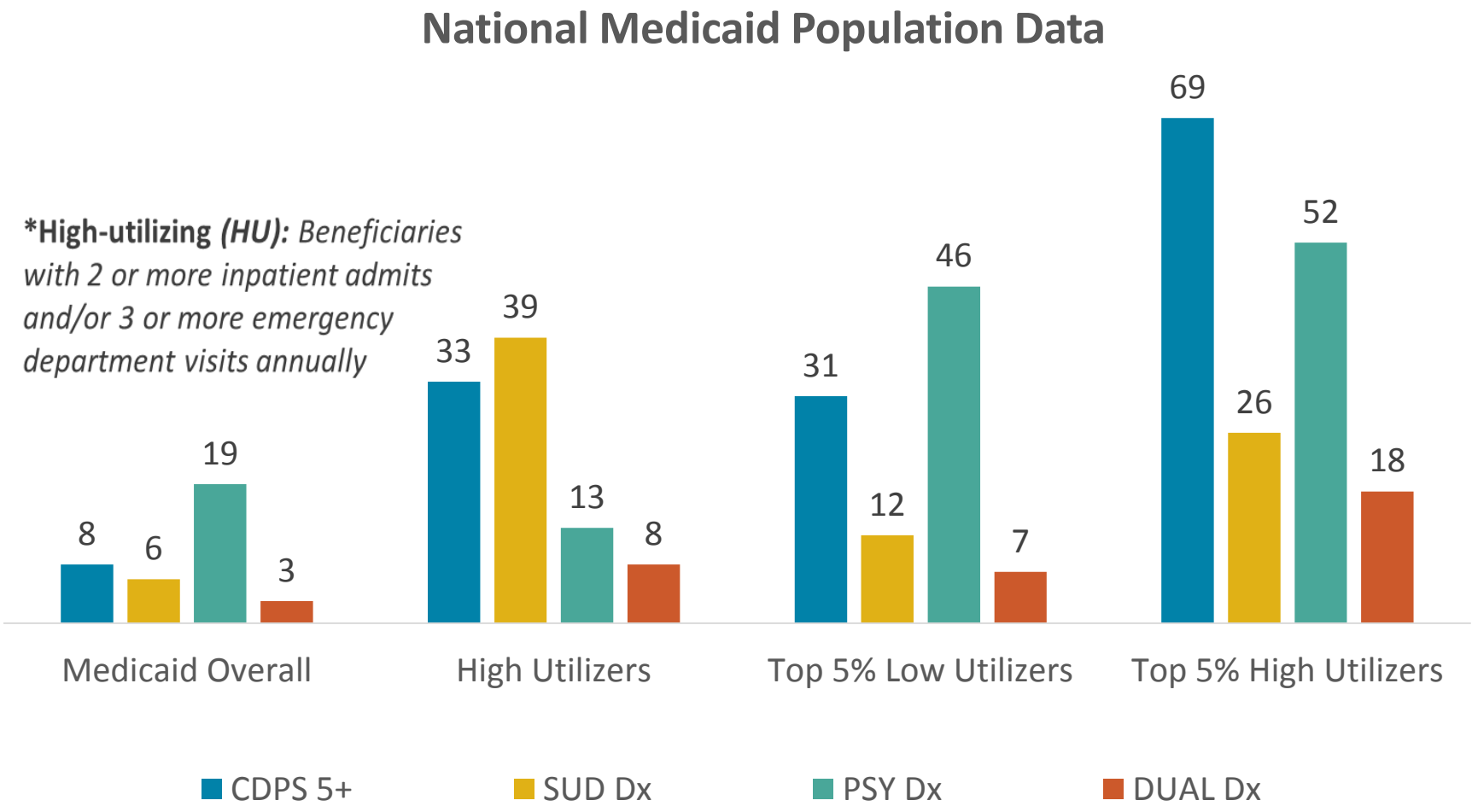
Accountable Entities Advisory Committee

January 30, 2019

12 States currently have Medicaid ACO programs



Serving People with Complex Health and Social Needs is Key to ACO Success



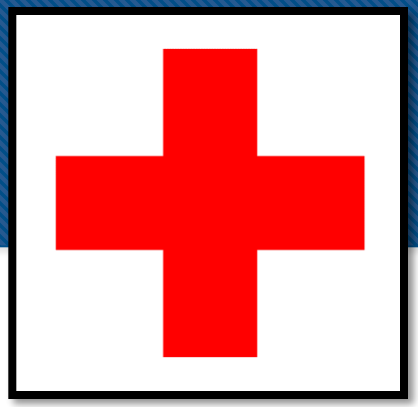
Four ways States can Meaningfully Include Behavioral Health in their ACO programs

1. Including behavioral health in total cost of care
2. Utilizing behavioral health metrics in ACO quality scoring
3. Developing behavioral health ACO application/ regulatory requirements
4. Aligning with existing behavioral health initiatives

Including Behavioral Health in Total Cost of Care

- At least 7 of 12 states include BH in their ACO total cost of care calculations
- Including BH in total cost of care incentivizes ACOs to meaningfully integrate care among physical health and behavioral health providers
- **Pro:** BH cost performance is directly tied to ACO success and shared savings
- **Con:** BH costs may actually rise as patients are connected to services, though physical health costs may fall as a result.

Utilizing Behavioral Health Metrics in ACO Quality Scoring



- Almost all states include at least one BH metric. Common measures include:

Follow-up after Hospitalization for Mental Illness ☑	Screening for clinical depression and documentation of follow-up plan
Screening for Clinical Depression & Follow-up Plan ☑	Depression remission at six months
Initiation and engagement of alcohol and other drug dependence treatment	Anti-depressant medication management

- **Pro:** Can track and hold ACOs accountable for performance on these metrics
- **Con:** Can **only** assure track and hold ACOs accountable for performance on **these** metrics

Developing BH ACO Application or Regulatory Requirements

- States can require ACO to meaningfully include BH in their programs
  - Examples include:
    - Including BH in program goals (many states)
    - Requiring a plan for addressing BH in application (IA)
    - Requiring contractual relationship with BH providers (ME, NJ)
    - Requiring BH providers to be represented in ACO governance (VT)
- **Pro:** Ensures that ACOs are committed/ready to address behavioral health needs
- **Cons:** Application requirements are only a "gate;" Requirements are hard to enforce in practice

Aligning with Existing BH Initiatives

- Many states align BH programs that exist outside or independently from their ACO programs with their ACO program
  - Examples include: PCMH, Health Homes, SUD pilot programs
  - Methods include:
    - Carve out: Patients involved in other programs not part of ACO program (NY)
    - Attribution: Patients attributed to ACO based on BH initiative participation (ME)
    - Alignment: Programs are complementary and meaningfully linked (ME)
- Pro: Alignment ensures you are working in an orderly fashion to a common goal
- Con: Much easier said then done

The Devil IS in the Details

- Simply including BH in an ACO program is not enough
  - **TCOC:**
    - Should all BH costs be included?
    - Are costs benchmarked and risk adjusted correctly?
  - **Quality:**
    - Is the model using right metrics?
    - Are metrics being measured, risk adjusted and benchmarked correctly?
  - **Regulations:**
    - Are right BH regulations in place?
    - Can BH regulations be continually enforced?

Alignment May be the Most Devilish Detail

- A lot of things can go wrong due to lack of alignment
  - Care fragmentation
    - Different patients assigned to different providers in different programs
    - Different data delivered for different programs
    - Different care management requirements/approaches
    - Different staff/department managing program
  - Provider burnout
    - Different quality metrics and benchmarks
    - Different program requirements, regulations
  - Perverse incentives
    - Financial incentives do not align across programs
    - Different program goals

Additional Integration Challenges

- Workforce shortages
- Lack of data availability to manage referrals
- Insufficient behavioral health care training for primary care providers
- Different regulatory and billing procedures

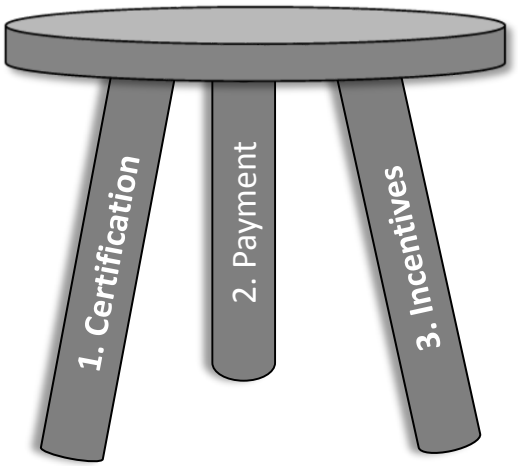
An ACO Alignment Example: Maine

- Maine had an existing health home program and wanted to build an ACO program (Accountable Communities or ACs)
  - ACs serve larger population than health homes, but excluding that population from ACs would undermine program goals
  - Health homes have 90/10 match –didn't want to lose that
- "Bike and rider" approach
  - ACs are "bike" that the Health home "rider" can use as a vehicle
  - ACs were not required to be health homes or vice versa, but the "bike" provides additional benefits **"Beats Walkin' "**
  - Health homes are first layer of attribution
  - Providers can only join one AC

An ACO Alignment Example: Maine

- Helpful state-level alignment:
  - Close relationship between AC and health home program staff, common reporting structure
  - Quality programs both managed by Maine Quality Counts
- In practice:
  - Health homes joined ACs (multiple health homes practices joined together become larger ACs)
  - Non-duplication provision ensured patient alignment
  - HH provided upfront PMPM for improvement, AC provided backend incentive
- Saved $12.7M over 2 years ($4.56M in Y1; $8.14M in Y2)

Discussion: How can RI Improve on BH Integration in its AE Program?



HSTP Updates

Incentive program for MCOs and AEs is underway; $3.1 million of $21.0 million Program Year 1 incentive funds have been awarded.

Technical Assistance to AEs by the Center for Healthcare Strategies is on-going; a second onsite Learning Collaborative is currently being scheduled for May.

HSTP is currently funding 20 healthcare workforce transformation projects at URI, RIC, and CCRI for a total of $2.4 million.

A forum for collaboration between AEs and higher education representatives has been established. Upcoming meeting in March will focus on continuing education.

Program Year 2 Accountable Entity program requirement documents were submitted to CMS in December.

Public Comment

Adjourn

Appendix

Backup: Analytic Methodology

Data Sources

- MMIS claims file (SFY 16-18)
- MCO monthly AE attribution reports by AE (SFY 16-18)
- The AE data set was created by stamping claims data based on monthly AE attribution records to create a data set in which AE attributed members are associated to claims

Data Set Adjustments

- Completion factor: SFY 18 claims data is paid through Sep-2018; a completion factor has been incorporated such that the data is estimated at 100% complete
- Tufts members and claims costs have been excluded from this analysis due to a lack of claims data and resulting skew (~3,700 total SFY 18 average eligibles)

Data Limitations

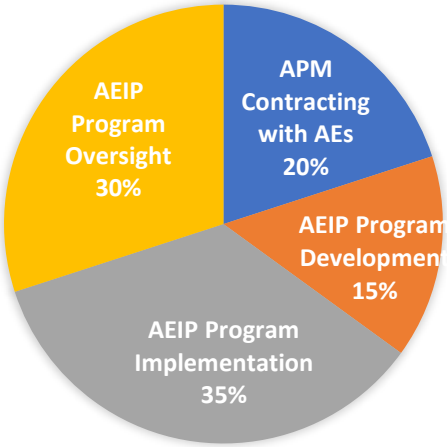
- Missing/rejected/disputed MC-837 claims have not been appended and represent 2-5% of total expenditures, impacting all years (SFY 16-18)
- A small number of AE attributed members are not associated with an AE name (~250 avg. eligibles; $6.4 M total expenditures for SFY 18); these members are not included in by AE breakdowns shown

AE Incentive Program: Program Year 1 and 2 Funding Distribution

Program Year 1 Incentive Funding ($21 M)

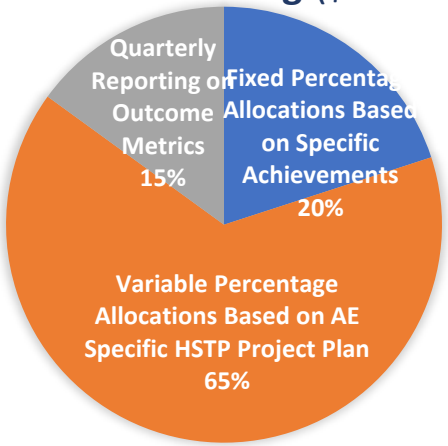
AE Incentive Pool ($18.9 M)

MCO Incentive Management Pool ($2.1 M)

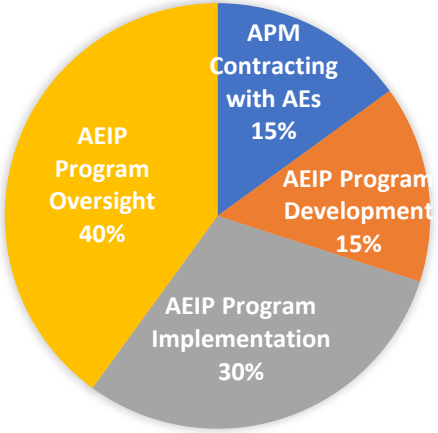


Program Year 2 Incentive Funding ($22.5 M)

AE Incentive Pool ($19.1 M)



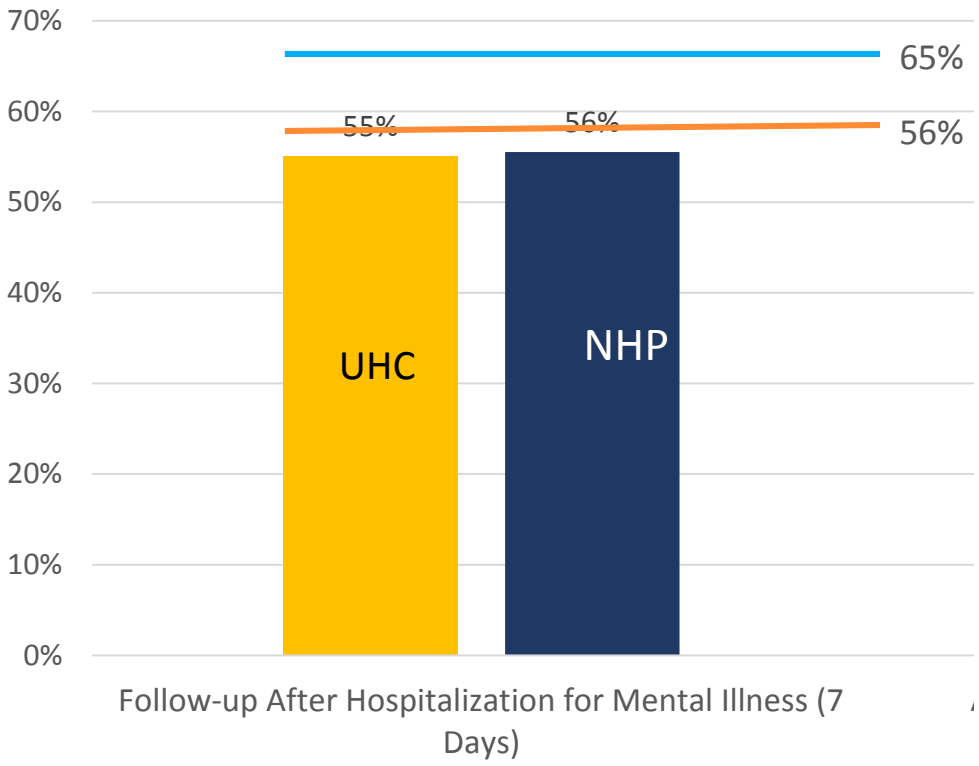
MCO Incentive Management Pool ($3.4 M)



Payment Backup
Baseline Behavioral Health Measure Performance by MCOs

In 2018, neither NHP nor UHC fully met the incentive award target for Follow up After Hospitalization for Mental Illness (7 days) in the MCO Performance Goal Program (PGP).

Follow up After Hospitalization for Mental Illness (7 Days)
MCO Performance Goal Program 2018



Full Incentive Award Target
Quality Compass® 2017 90th percentile

Partial Incentive Award Target
Quality Compass® 2017 75th percentile

Source: Performance Goal Program 2018 Incentive Report

Reminder: AE Program Timeline

- Two Year Pilot Program began in SFY 2017
- Transitioned from Pilot to “full program” implementation in SFY 2019
- HSTP incentive funding authority has been confirmed via the newly approved 1115 waiver renewal

(1) AE Certification and BH Integration

1. Breadth and Characteristics of Participating Providers

- Building provider base, population specific provider capacity, interdisciplinary partnerships, CBO affiliations
- Developing full continuum of services, Integrated PH/BH, Social determinants

2. Corporate Structure and Governance

- Establishing distinct corporation, with interdisciplinary partners joined in a common enterprise

3. Leadership & Management

- Establishing an initial management structure/staffing profile
- Developing ability to manage care under Total Cost of Care (TCOC) arrangement with increased risk

4. IT Infrastructure: Data Analytic Capacity & Deployment

- Core infrastructure: EHR, patient registries, Current Care
- Provider/care managers' access to information: Lookup capability, medication lists, shared messaging
- Patient portal
- Analytics for population segmentation, risk stratification,
- Integrating analytic work with clinical care: Clinical decision support tools, early warning systems, alerts

5. Commitment to Population Health & System Transformation

- Developing an integrated strategic plan for population health that is population based, data driven, evidence based, client centered, recognizes Social Determinants of Health, team based, integrates BH, IDs risk factors
- Healthcare workforce planning and programming

6. Integrated Care Management

- Systematic process to ID patients for care mgt
- Defined Coordinated Care Team, with specialized expertise and staff for distinct subpopulations
- Individualized person-centered care plan for high risk members

7. Member Engagement & Access

- Defined strategies to maximize effective member contact and engagement
- Use of new technologies for member engagement, health status monitoring and health promotion

8. Quality Management

- Defined quality assessment & improvement plan, overseen by quality committee

Challenge 2: What is an AE - Certification Standards

1. Breadth and Characteristics of Participating Providers

1.1. Provider base
1.2 Relationship of Providers to the AE
1.3 Ability to Coordinate for all levels of need for attributed pop
1.4 Defined methods to care for people with complex needs
1.5 Ability to ensure timely access to care

2. Corporate Structure and Governance

2.1. Multiple entity applicant: Distinct Corporation
2.2 Single Entity Applicant
2.3 Governing board or Governing Committee: Interdisciplinary
2.4. Compliance
2.5. Required: an executed contract with an MMCO

3. Leadership & Management

3.1 Leader: CEO or program manager
3.2 Management structure/staffing profile
3.3 Prepared for TCOC

4. IT Infrastructure: Data Analytic Capacity & Deployment

4.1 Core data infrastructure and provider & patient portals
4.2 Provider and care manager access to information
4.3 Using data analytics for population segmentation, risk stratification, predictive modeling
4.4 Reshaping workflows by deploying analytic tools
4.5 Integrating analytic work with clinical care & care mgt processes
4.6. Staff Development - Training

5. Commitment to Population Health & System Transformation

5.1 Key Population Health Elements
5.2 Social Determinants of Health
5.3 System Transformation and the Healthcare Workforce

6. Integrated Care Management

6.1 Systematic Processes to Identify Patients for Care Mgt
6.2 Defined Care Mgt Team with Specialized Expertise Pertinent to Characteristics of Target Population
6.3 Individualized Person Centered Care Plan for High Risk Members

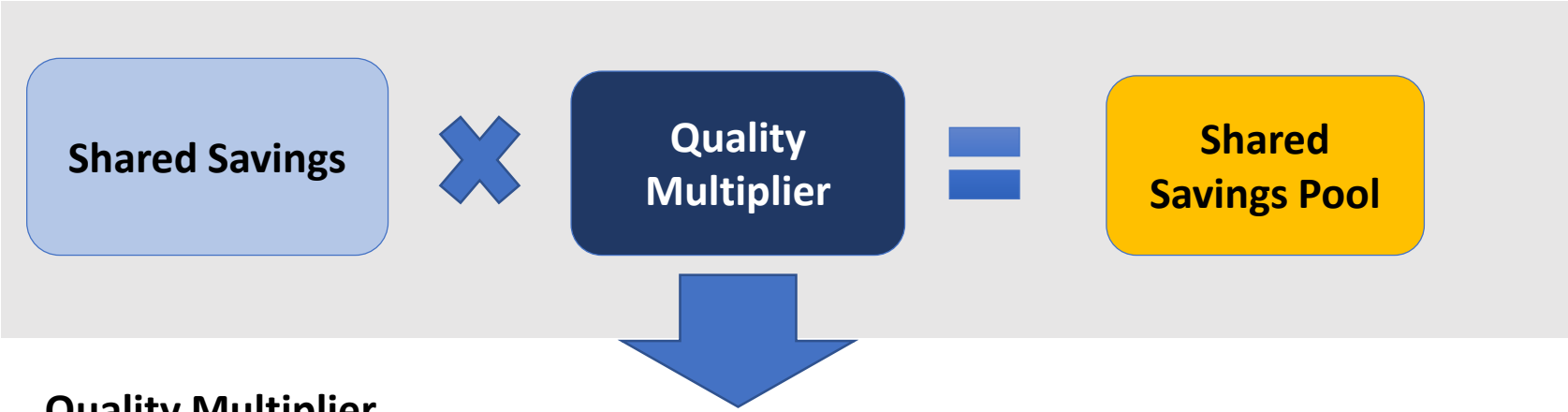
7. Member Engagement & Access

7.1 Defined Strategies to Maximize Effective Member Contact and Engagement
7.2 Implementation, Use of New Technologies for Member Engagement, Health Status

8. Quality Management

8.1. Quality Committee and Quality Program
8.2 Methodology for the Integration of Medical, Behavioral, and Social Supports
8.3 Clinical Pathways, Care Management Pathways, and Evidence Based Practice
8.4 Quality Performance Measures

(2) Payment: Shared Savings and BH Integration



Quality Multiplier

- 11 measure AE Common Measure Slate*
- Includes 2 Behavioral Health related measures
  - Follow-up after Hospitalization for Mental Illness (7 day & 30 day)**
  - Screening for Clinical Depression and Follow-up Plan
- Facilitated Quality Measure Development Process underway (Supported by Bailitt Health)

* Overall, at least 3 measures must be pay-for-performance in PY 2 (two required measures and at least one additional measure that is agreed to by the MCO/AE)

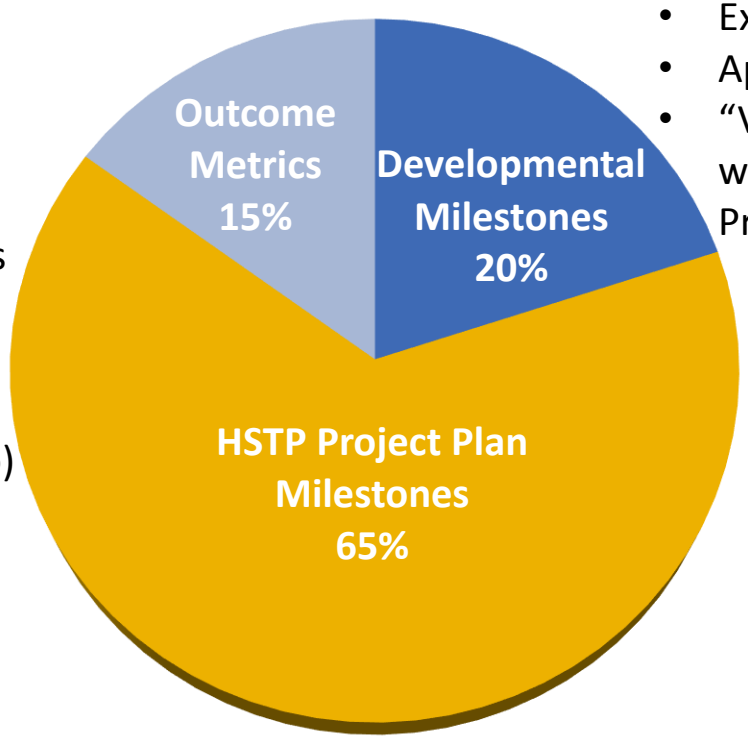
** One of the Follow-up after Hospitalization for Mental Illness measure components must be P4P in PY 2 (both components must be reported, one must be selected as PFP)

(3) Incentives: AE Incentive Pool and BH Integration

PY 2 AE Incentive Pool = $19.1 M

Outcome Metrics

- Overall & High Utilizers
- Metrics
  - IP Admits per 1,000
  - 30 Day Readmissions
  - ED Visits per 1,000
  - ACS ED Visits
  - MCO/AE Specific Targets (at least two)



Developmental Milestones

- Executed APM contract
- Approved HSTP Project Plan
- "Value based agreement" with SDOH, BH, and/or SUD Provider*

HSTP Project Plan

- EOHHS Priority Areas
  Behavioral health care, SUD treatment, Social determinants
- Structure: Core projects, milestones
  Eligible core projects must clearly address EOHHS priority areas
- EOHHS defined Project Plan Template

* Value based agreement to include one or more of the following: foundational payments for infrastructure and operations, pay for reporting, rewards for performance, or rewards and penalties for performance